MIND BODY SHINE – HEALTH CONSULTATION FORM

NAME: Mr/Mrs/Ms/Miss D.O.B. DATE

REFERRED BY:

FAMILY SITUATION:

PROFESSION:

ADDRESS:

POST CODE:

CONTACT NUMBER:
(M)
(H)

E-MAIL:

G.P.:
ADDRESS:

POST CODE:

TELEPHONE:

EXPERIENCE OF COMPLEMENTARY ALTERNATIVE MEDICINE TO DATE

PRESENTING COMPLAINT/S

MEDICAL HISTORY

FAMILY MEDICAL HISTORY

MEDICATIONS (Current and Past)

SUPPLEMENTS (Current and Past)

ENERGY LEVELS

SLEEP PATTERNS

DIET

Typical Breakfasts:

Typical Lunches:

Typical Dinners:

Typical Snacks:

Coffee/Tea Intake:

Fizzy Drinks:

Water Consumption:

Cravings:

Aversions:

Food allergies and sensitivities:

DIGESTION and GI

RESPIRATORY

IMMUNE SYSTEM

NERVOUS SYSTEM and HEAD (headaches, etc)

MENSES (Women)

LIBIDO:

GENITOURINARY TRACT

MUSCULOSKELETAL and PAIN

SKIN:

HAIR:

NAILS:

STRESS

LIFESTYLE
Social Network: Smoking: Drinking/recreational:

EXERCISE

HEIGHT	WEIGHT	BMI or BIA
	OPTIMAL WEIGHT	OPTIMAL BMI

Confirmation and Consent

I understand that to receive the most effective and safe treatment, it is of utmost importance that I disclose all relevant medical information accurately and completely, and that withholding and/or falsifying any relevant medical information may compromise safe treatment and/or have an adverse effect on my health.

I understand that the treatment is not designed to act as a substitute for a full medical assessment, or to comprehensively identify and treat existing or future potential conditions.

I further confirm that I have read and understood the possible side effects set out above related to the specific complementary and alternative medical treatments, and that my questions regarding the procedures as well as any other questions I have raised related to my treatment and/or testing, have been answered fully to my satisfaction prior to signing this consent Form.

I give my consent to receiving my selected treatment and/or procedures. I agree that insofar as is permissible by applicable law, my practitioner shall not be responsible and shall not assume any liability for any damage to or loss of the property or belongings of any client, whether such damage or loss is caused by negligence or otherwise. I agree to fully indemnify and hold harmless my practitioner from and against all liabilities, claims, expenses, damages and losses, including legal fees (on an indemnity basis), arising out of or in connection with the treatments and/or services.

Client's Signature ______________________________

Print Name ______________________________

Date ______________________________